

Interjurisdictional Tuberculosis Notification

Referring

Jurisdiction city county state Date sent / /

Contact person Phone () FAX ()

☐ Verified case → State where reported: RVCT# (attach RVCT) ☐ Not reported

☐ Suspect case ☐ Close contact ☐ Reactor LTBI ☐ Convertor ☐ Source case investigation

Patient name Sex ☐ Male ☐ Female
Last First Middle

Date of birth / / Interpreter needed? ☐ No ☐ Yes, specify language

New address Hispanic ☐ No ☐ Yes
Number/Street/Apt. Race ☐ White ☐ Black ☐ Asian
 ☐ Am. Indian/Nat. Alaskan.
City/State/ZipCode ☐ Other:

New telephone () Date of expected arrival / /

New health provider: Unknown Known (name, address, phone)

Insurance source: None Medicaid Private Medicare Other

Emergency contact: Name Phone

Laboratory information for this referred case/suspect index case for this contact not applicable

Date	Specimen type	Smear	Culture	Susceptibility	Chest X-ray	Other pertinent labs

Site(s) of disease: Pulmonary Other(s) specify all

Date 1st negative smear / / Not yet Date 1st negative culture / / Not yet

TB skin test #1: Date / / Result mm TB skin test #2: Date / / Result mm

Contact/LTBI Information **TB Skin test** Not Done

TST #1 Date / / Result mm TST#2 Date / / Result mm

CXR Not Done Date / / Normal Other:

Last known exposure to index case / / Place/intensity of exposure:

Medications ☐ this referred case/suspect ☐ this referred contact/LTBI

Drug	Dose	Start date	Stop date

Planned completion date / /

DOT No Yes: start date / /

Daily 1x W 2x W 3x W

Last DOT Date / /

Adherence problems/significant drug side effects:

Comments

Case Follow-Up In 30 days report to referring jurisdiction if located or not located and report final outcome.

Other Follow-Up Follow-up requested (form attached) No follow-up requested